MEDICAL STATEMENT

FOR CHILDREN WITH DISABILITIES REQUIRING SPECIAL NEEDS IN CHILD NUTRITION PROGRAMS

PART I

Date _____

Child's Name_____ Age_____

School District _____ School_____

PART II (To Be Completed By Physician)

Diagnosis: _____

Describe the child's disability and the major life activity affected by the disability: _____

_____

Does the disability restrict the child's diet? Yes _____ No _____

List dietary restrictions or special diet: _____

_____

List allergies or food intolerances: _____

_____

List foods that require a change in texture: _____

_____

List required special equipment: _____

_____

Date _____Signature of Physician _____

PART III (Parent/Guardian Signature)

Date _____Signature of Parent/Guardian _____